August 19, 2003

MDR Tracking #: M2-03-1570-01
IRO #: 5251

___ has been certified by the Texas Department of Insurance as an Independent Review Organization. The Texas Worker's Compensation Commission has assigned this case to ___ for independent review in accordance with TWCC Rule 133.308 which allows for medical dispute resolution by an IRO.

___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, all relevant medical records and documentation utilized to make the adverse determination, along with any documentation and written information submitted, was reviewed.

The independent review was performed by a matched peer with the treating doctor. This case was reviewed by a licensed Medical Doctor with a specialty and board certification in Physical Medicine and Rehabilitation. The ___ health care professional has signed a certification statement stating that no known conflicts of interest exist between the reviewer and any of the treating doctors or providers or any of the doctors or providers who reviewed the case for a determination prior to the referral to ___ for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to the dispute.

CLINICAL HISTORY

___ is now sixty years of age. He works for the police department and is being treated in the ___ area for a ___ lumbar injury. His diagnosis is that of a lumbar disc injury with lumbar radiculopathy.

There was demonstrated adequate trial and long-term use of this device. Included is a record of the large number of hours of the patient's use of the stimulator unit over a period of several months, including dates as recent as July, 2003. The records indicate satisfactory and helpful pain reduction benefit subjectively from the unit, increased elevation of activity because of this, increased exercise tolerance, and is now back at work. He is taking what is judged to be a greatly reduced amount of pain medication.

Multiple reports from ___ were reviewed, including January, March, and May. Carrier notations indicate that there were two reviews earlier on this issue in this case with negative recommendations by ___, physical medicine, and ___, orthopedics, Austin, Texas, but these reports were not available for review.

REQUESTED SERVICE

The purchase of an interferential muscle stimulator is requested for this patient.

DECISION

The reviewer disagrees with the prior adverse determination.

BASIS FOR THE DECISION

Literature reveals many situations in which true benefit from a stimulator cannot be identified in controlled studies. However, there are a certain percentage of cases in the literature documenting patients who have used their stimulators rather consistently in their daily living and have been found to control/diminish their pain through the use of these devices. In this case, the reviewer finds that the purchase an interferential muscle stimulator is reasonable and justifiable.

___ has performed an independent review solely to determine the medical necessity of the health services that are the subject of the review. ___ has made no determinations regarding benefits available under the injured employee's policy.

As an officer of ___, I certify that there is no known conflict between the reviewer, ___ and/or any officer/employee of the IRO with any person or entity that is a party to the dispute.

___ is forwarding by mail and, in the case of time sensitive matters by facsimile, a copy of this finding to the treating doctor, payor and/or URA, patient and the TWCC.

Sincerely,

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

In the case of prospective ***spinal surgery*** decision, a request for a hearing must be made in writing and it must be received by the TWCC Chief Clerk of Proceedings within 10 days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

In the case of other ***prospective (preauthorization) medical necessity*** disputes a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d). A request for a hearing should be sent to: Chief Clerk of Proceedings, Texas Worker's Compensation Commission, P.O. Box 40669, Austin, TX 78704-0012. A copy of this decision should be attached to the request.

The party appealing this decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute, per TWCC rule 133.308(t)(2).

I hereby certify, in accordance with TWCC Rule 102.4 (h), that a copy of this Independent Review Organization decision was sent to the carrier, requestor, claimant (and/or the claimant's representative) and the TWCC via facsimile, U.S. Postal Service or both on this 19th day of August, 2003